



JOHN M. SHIE, M.D. CAROLINE H. KENNEBECK, M.D. KELLY L. McCLUSKEY, M.D.  
SHANNON N. McAFEE, D.O. JENNIFER A. MITTLESTEAD, M.D. SAMANTHA E. HOUSER, D.O.

## Registration Form

### Patient Information

Last Name:		First Name:		Middle Name:		Maiden Name:						
Address:			City/State:			Zip:						
DOB:		Age		S.S. #		Home Phone:						
Employer Name:			Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Part time <input type="checkbox"/> Not Employed			Work Phone:						
						Cell Phone:						
Referring Physician:			Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W			Pharmacy/Location:						
Email:			Language:		Race:		Pharmacy Phone:					
How did you hear about us? <input type="checkbox"/> Other _____			<input type="checkbox"/> Insurance <input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Drive-By <input type="checkbox"/> Internet		<input type="checkbox"/> Newspaper <input type="checkbox"/> Family/Friend		<input type="checkbox"/> Special Events <input type="checkbox"/> Magazine		<input type="checkbox"/> Hospital <input type="checkbox"/> Physician Ref.	

☐ Same as patient

### Responsible Party Information (If different from patient)

*Person who accompanies child to visit*

Last Name:		First Name:		Birthdate:		
Address:			S.S. #		Relationship to patient:	
Home Phone:		Cell Phone:			Work Phone:	

### Emergency Contact (spouse or nearest relative)

Emergency Contact Name:		Phone Number:	
Is it OK to leave message with ER contact? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relation to Patient:	

### Primary Insurance Information

Insurance Company:		Group# / Plan ID:		Member Number:		
Subscriber Employer Name:		Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Child to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Other			Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber Name:		Subscriber DOB:			Copay:	

### Secondary Insurance Information

Insurance Company:		Group# / Plan ID:		Member Number:		
Subscriber Employer Name:		Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Child to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Other			Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber Name:		Subscriber DOB:			Copay:	

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to Far Hills OB/GYN, Inc. to render needed treatment and/or tests for the above named patient.
2. I authorize Far Hills OB/GYN, Inc. to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to Far Hills OB/GYN, Inc., realizing I am responsible to pay noncovered and unauthorized service.
4. If you are unable to keep your appointment, 24 hour cancellation notice is required. If you miss your appointment without notifying our office, you will be charged \$25.00 after the third occurrence and each time thereafter. This charge is not billable to your insurance. **If you are more than ten minutes late for an appointment, you will need to reschedule. It is unfair to our other patients to make them wait when they have arrived on time.**
5. Return Check Fee, you are charged \$35.00 if your check is returned from the bank.
6. 1.5% late fee is charged on unpaid balances over 90 days.

The above information is correct / Patient or Guardian Signature

Date

(over) →



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### Statement of Release

The purpose of this form is to give the physicians and staff of this office permission to release your medical information (such as lab or test results) to any person you designate when we are unable to reach you. This will also allow us to give your medical information to a friend or family member who may call on your behalf. This consent will remain in effect until updated by you. Please read carefully and sign below.

I hereby authorize the physicians and/or clinical staff of Far Hills OB/GYN, Inc. to release information pertaining to my patient file to the following person(s):

(Name) _____	(Telephone) _____	(Relationship) _____
(Name) _____	(Telephone) _____	(Relationship) _____
(Name) _____	(Telephone) _____	(Relationship) _____
(Name) _____	(Telephone) _____	(Relationship) _____
(Name) _____	(Telephone) _____	(Relationship) _____

☐ I DO NOT authorize the physicians and/or clinical staff of Far Hills OB/GYN, Inc. to release information pertaining to my patient file to any person(s).

PATIENT SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_

Messages may be left on my answering machine / cell phone / voice mail:

☐ YES

☐ NO



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## Medical History

**PLEASE ANSWER ALL QUESTIONS ON THIS FORM**

Date \_\_\_\_\_

Patient's name \_\_\_\_\_ Birth date \_\_\_\_\_

Who referred you here? \_\_\_\_\_

What is your main problem for coming to the doctor today? \_\_\_\_\_

Are you taking any medicines, including birth control pills? Please list all medications: \_\_\_\_\_

Which type of birth control do you use if any? \_\_\_\_\_

Are you allergic to any medications? If you have any allergies please list reaction you have had: \_\_\_\_\_

When did your last period start? \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_

Have you ever had an abnormal pap smear, if so, please list date with results: \_\_\_\_\_

Have you ever had herpes or any sexually transmitted diseases? Please list: \_\_\_\_\_

Have you had previous surgery? \_\_\_\_\_

Dates & Types: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

If you have had any pregnancies, including miscarriages or others, please list all: \_\_\_\_\_

Date	Length of Labor (Hours)	Sex	Birth Weight	Complications
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

(over) ➔



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## Notice of Privacy Practices

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

**Ways in Which We May Use and Disclose Your Protected Health Information:** The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

**Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For example* -we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

**Payment.** We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* -we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

**Health Care Operations.** We will use and disclose your protected health information to support the business activities of our practice. *For example* -we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

### Other Ways We May Use and Disclose Your Protected Health Information:

**Appointment Reminders.** We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

**Treatment Alternatives.** We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

**Others Involved in Your Care.** We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

**Research.** We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**As Required by Law.** We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

**To Avert a Serious Threat to Public Health or Safety.** We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

**Worker's Compensation.** We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

**Inmates.** We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

(over) ➔

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## Acknowledgement of Receipt of Notice of Privacy Practices

*\*You May Refuse to Sign This Acknowledgement\**

I, \_\_\_\_\_  
have received a copy of this office's Notice of Privacy Practices.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign  
☐ Communication barriers prohibited obtaining the acknowledgement  
☐ An emergency situation prevented us from obtaining acknowledgement  
☐ Other (Please Specify) \_\_\_\_\_



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## Health History Form

Have you or an immediate member (mother, father, sister, brother or grandparent) ever had any of the following conditions?

*Check and detail positive findings including date and place of treatment. Precede findings by reference number.*

	Patient	Family
1. Congenital anomalies .....	_____	_____
2. Genetic diseases .....	_____	_____
3. Multiple births .....	_____	_____
4. Diabetes mellitus .....	_____	_____
5. Malignancies.....	_____	_____
6. Ovarian cancer .....	_____	_____
7. Breast cancer .....	_____	_____
8. Hypertension .....	_____	_____
9. Heart attack .....	_____	_____
10. Stroke .....	_____	_____
11. Rheumatic fever .....	_____	_____
12. Pulmonary disease .....	_____	_____
13. GI problems .....	_____	_____
14. Renal disease.....	_____	_____
15. Genitourinary tract problems .....	_____	_____
16. Abnormal uterine bleeding.....	_____	_____
17. Infertility .....	_____	_____
18. Venereal disease.....	_____	_____
19. Blood clots – leg or lung .....	_____	_____
20. Phlebitis varicosities .....	_____	_____
21. Emotional / psychological disorders .....	_____	_____
22. Neurologic disorder .....	_____	_____
23. Headaches / migraines.....	_____	_____
24. Metabolic / endocrine disorders.....	_____	_____
25. Anemia / hemoglobinopathy .....	_____	_____
26. Blood disorders.....	_____	_____
27. Infectious diseases .....	_____	_____
28. Skin problems.....	_____	_____
29. Operations / accidents.....	_____	_____
30. Allergies / meds sensitivity .....	_____	_____
31. Blood transfusions .....	_____	_____
32. Other hospitalizations .....	_____	_____
33. Thyroid disease .....	_____	_____
34. Arthritis .....	_____	_____
35. No known diseases / problems	_____	_____

Do you drink alcohol? \_\_\_\_\_ If so, how many drinks per week? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ If so, what do you use? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_ Would you like to quit? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_ Would you like to quit? \_\_\_\_\_

Name: \_\_\_\_\_



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### Financial Policy

1. All co-pay / co-insurance amounts are due at each visit or procedure.
2. Charges not covered by insurance are due at the time of service.
3. Balances remaining after insurance payment, are due within 30 days.
4. Any unpaid balance after 90 days will be charged a service charge / late fee of 1.5 % per month until the account is paid in full.
5. We accept cash, check, Visa, Mastercard and Discover.
6. There is a returned check fee of \$35.00 for any checks returned without payment from your bank.

### Maternity Care / Surgery

1. Insurance benefits for maternity / surgery will be verified through your insurance carrier. For maternity, monthly payments will be established through the months of your prenatal care, so that your out-of-pocket expenses are credited two months prior to your due date.
2. For surgery, a prepay deposit may be requested, depending upon your out-of-pocket expenses as quoted by your insurance carrier.

### Collection Accounts

1. **If you allow your account to go to collection, you are notifying our office that you are terminating the doctor / patient relationship.**
2. If your account has been sent to collection, after paying the entire balance plus late fees, you will be on a PAYMENT AT TIME OF SERVICE for one year. You then will be permitted to return to a normal pay structure.
3. If your account has been sent to collection TWICE, you may return to our office after clearing your collection balance and fees. You will be put on a permanent PAYMENT AT TIME OF SERVICE basis.
4. Accounts are sent to collection starting at 90 days unless payment arrangements have been made. You will be responsible for balance due and late fees of 1.5% / 18% annually.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED BY MY INSURANCE. PAYMENT IS EXPECTED AT THE TIME OF MY VISIT. IF THIS CAN NOT BE DONE, I AGREE TO MAKE OTHER ARRANGEMENTS WITH THE BILLING DEPARTMENT. I ALSO AGREE TO PAY ANY FEES FROM ANY PAST DUE AMOUNTS.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date